Med Center Health

Student Health Questionnaire

Student's Name _____ DOB: _____

School: Select School _____ Date Form Received By the School: _____

Primary Care Provider: _____ PCP Phone: _____

Please list any medications (Over-the-counter and prescription), vitamins, herbs, supplements currently taking or any oils currently using: _____

_____

_____

Please check if the child has a confirmed medical history of any of the following:

CARDIOVASCULAR
- ☐ Heart Murmur/Defect
- ☐ High Blood Pressure
- ☐ Pacemaker
- ☐ Life Pack/LVAD Heart Pump

DEVELOPMENTAL/PSYCH
- ☐ ADHD/ADD
- ☐ Developmental Delays
- ☐ Down Syndrome
- ☐ Autism
- ☐ Mood Problems/Depression

ENDOCRINE
- ☐ Heart Murmur/Defect

DIGESTIVE/RECTAL/URINARY
- ☐ Frequent Stomach aches
- ☐ Acid Reflux
- ☐ Wears Diapers
- ☐ Incontinence of Stool
- ☐ Recurrent Urinary Tract Infections

DIGESTIVE/RECTAL/URINARY
- ☐ Inability to void w/o Catheterization
- ☐ Kidney Disease
- ☐ Incontinence of Urine
- ☐ Ostomy
- ☐ Urinary Frequency
- ☐ Lactose Intolerant
- ☐ Constipation Requiring MD Visits
- ☐ Inability to eat w/o Tube Feeding

HEAD/EYE/EAR/NOSE/THROAT
- ☐ Dental Decay/Problems
- ☐ Frequent Sinus Infections
- ☐ Frequent Ear Infections
- ☐ Hearing Loss or Difficulty
- ☐ Vision Loss or Difficulty
- ☐ Migraine Headaches
- ☐ Head Injury
- ☐ Concussion in the past 3 years

HEMATOLOGIC
- ☐ Hemophilia
- ☐ Sickle Cell Anemia

DIGESTIVE/RECTAL/URINARY
- ☐ Inability to void w/o Catheterization

MUSCULOSKELETAL
- ☐ Spina Bifida

NEUROLOGICAL
- ☐ Neurological Problems
- ☐ Cerebral Palsy
- ☐ Seizures
- ☐ Postural Orthostatic Tachycardia Syndrome (POTS)

PULMONARY
- ☐ Cystic Fibrosis

REPRODUCTIVE
- ☐ Debilitating Menstrual Cramps

OTHER
- ☐ Genetic Disorder
- ☐ Immune Deficiency
- ☐ Inability to tolerate extreme heat

☐ **Other:** _____

☐ **Asthma** (*If checked, please mark what may bring on this child's asthma)

☐ Pollens ☐ Animals ☐ Illness ☐ Weather Changes ☐ Smoke ☐ Perfume
☐ Dust ☐ Foods ☐ Heat ☐ Scents ☐ Candles ☐ Seasonal Changes

☐ Other: _____

*What asthma symptoms does this child have? ☐ Coughing ☐ Shortness of Breath ☐ Wheezing

Other symptom _____

☐ Allergic Reaction confirmed by a medical provider to: ☐ Stinging Insects ☐ Red Dye ☐ Latex ☐ Animals ☐

☐ Food(s): _____

☐ Medication(s): _____

*What allergic reaction does this child have? ☐ Itching ☐ Hives/Rash ☐ Wheezing ☐ Swelling of Lips, Mouth, Tongue, Throat ☐ Nausea/Vomiting/Stomach Cramps ☐ Coughing ☐ Shortness of Breath ☐ Dizziness ☐ Unconsciousness ☐ Other _____

Parent/Guardian completing form signature: _____ Date _____ Time _____